<table>
<thead>
<tr>
<th>K 062</th>
<th>NFPA 101 LIFE SAFETY CODE STANDARD SS=E</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.8.12, NFPA 13, NFPA 25, 9.7.5</td>
</tr>
</tbody>
</table>

This STANDARD is not met as evidenced by:
- Based on observation, it was determined that 19 of 46 (100, 102, 103, 104, 105, 106, 107, 108, 109, 201, 203, 205, 206, 207, 301, 302, 303, 305 and 317) sprinkler heads in resident room closets were obstructed with a wooden divider.

The findings included:
- Observations on 10/11/10 beginning at 10:00 AM, revealed the sprinkler heads in the closets of resident rooms 100, 102, 103, 104, 105, 106, 107, 108, 109, 201, 203, 205, 206, 207, 301, 302, 303, 305 and 317 were obstructed with a wooden divider.

K 144 | NFPA 101 LIFE SAFETY CODE STANDARD SS=D |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1</td>
</tr>
</tbody>
</table>

This STANDARD is not met as evidenced by:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patient. (See Instructions.) Except for nursing homes, the findings stated above are discloseable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are discloseable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
K 144 Continued From page 1

Based on observation, it was determined that the facility failed to provide a remote annunciator from the generator to a continuously occupied area.

The findings included:

Observations of the building on 10/11/10 revealed that the facility failed to install a remote annunciator from the generator to a continuously occupied area as required.

K 144 continued from page 1

Corrective Action:
1. The facility will provide a remote annunciator from the generator to the nurse's station.
2. The facility will have a remote annunciator installed by December 8, 2010.
3. Administrator has either Nixia Power or Thompson CAT prepared to do installation.
4. Maintenance Director will monitor annunciator readings during weekly generator exercise.